

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11944

11960

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>202 Center St</b>		d. STREET ADDRESS <b>1 202 Center St</b>	
3. NAME OF DECEASED (Type or print) <b>MORRIS SLEMMONS ADAMS</b>		4. DATE OF DEATH <b>OCTOBER 11 th, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 15, 1897</b>
9. AGE (In years last birthday) <b>61 yrs.</b>		10. IF UNDER 1 YEAR <b>9 Months 26 Days</b> IF UNDER 24 HRS. <b>Hours Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee-Md. State Roads Commission</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wicomico County Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Adams</b>		14. MOTHER'S MAIDEN NAME <b>Hettie Ennis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT Mrs. Anna C. Adams (Wife) 202 Center St. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Coronary Occlusion</b> DUE TO (b) <b>Arterio-sclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <b>year</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchogenic Carcinoma - Rt. Lobectomy 4-21-59</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12-7</b> , 19 <b>54</b> , to <b>10-11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9-28</b> , 19 <b>59</b> , and that death occurred at <b>7:55 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Earl L. Royer</b> M.D.		ADDRESS (Street, city or town, state) <b>October 12/1959</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Dr. Earl L. Royer</b>		<b>407 Camden Ave. Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 14, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>OCT 13 '59</b> DATE	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanks</b>

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CERTIFICATE OF DEATH

1930

Historical

Epiphany

St. George

ROBERTA ELLIOTT ADAMS

Dec. 22, 1930

St. George, N. Y.

Robert Adams

St. George, N. Y.

St. George, N. Y.

St. George, N. Y.

St. George, N. Y.

St. George, N. Y.

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St. George, N. Y.

St. George, N. Y.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11945

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WICOMICO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WICOMICO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FRUITLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FRUITLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GREEN ST</b>		d. STREET ADDRESS <b>GREEN ST.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WALTER</b> Last <b>BANKS</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>13</b> Year <b>th 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 10, 1901</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Repairman-Mechanic-Self-employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fruitland, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John F. Banks</b>		14. MOTHER'S MAIDEN NAME <b>Alverta Brumbley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>212-12-3864</b>	
17. INFORMANT <b>Mrs. Alma V. Banks (Wife)</b>		Address <b>Green St. Fruitland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shot gun wound upper abdomen</b> DUE TO <b>976x</b> Conditions, if any, which gave rise to immediate cause (b) <b>sudden</b> (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b> DUE TO <b>sudden</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self inflicted</b>	
20c. TIME OF INJURY Month, Day, Year <b>12:05 p.m. 10 13 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Fruitland</b> (County) <b>Wicomico</b> (State) <b>MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 16, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Zion Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Fruitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>Oct 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
John F. Smith		Male		35		October 10, 1933	
5. Place of Death		6. Cause of Death		7. Manner of Death		8. Signature of Medical Examiner	
Home		Heart Disease		Natural		[Signature]	
9. Residence		10. Occupation		11. Education		12. Marital Status	
Baltimore, Md.		Teacher		High School		Married	
13. Date of Birth		14. Date of Admission to Hospital		15. Date of Discharge		16. Date of Death	
October 10, 1933						October 10, 1933	
17. Name of Physician		18. Name of Hospital		19. Name of Nurse		20. Name of Undertaker	
Dr. J. H. Jones		St. Mary's Hospital		Miss M. White		Mr. A. Black	
21. Name of Coroner		22. Name of Jury		23. Name of Witness		24. Name of Juror	
Mr. C. Green		None		None		None	
25. Name of Juror		26. Name of Juror		27. Name of Juror		28. Name of Juror	
None		None		None		None	
29. Name of Juror		30. Name of Juror		31. Name of Juror		32. Name of Juror	
None		None		None		None	
33. Name of Juror		34. Name of Juror		35. Name of Juror		36. Name of Juror	
None		None		None		None	
37. Name of Juror		38. Name of Juror		39. Name of Juror		40. Name of Juror	
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41. Name of Juror		42. Name of Juror		43. Name of Juror		44. Name of Juror	
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45. Name of Juror		46. Name of Juror		47. Name of Juror		48. Name of Juror	
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49. Name of Juror		50. Name of Juror		51. Name of Juror		52. Name of Juror	
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53. Name of Juror		54. Name of Juror		55. Name of Juror		56. Name of Juror	
None		None		None		None	
57. Name of Juror		58. Name of Juror		59. Name of Juror		60. Name of Juror	
None		None		None		None	
61. Name of Juror		62. Name of Juror		63. Name of Juror		64. Name of Juror	
None		None		None		None	
65. Name of Juror		66. Name of Juror		67. Name of Juror		68. Name of Juror	
None		None		None		None	
69. Name of Juror		70. Name of Juror		71. Name of Juror		72. Name of Juror	
None		None		None		None	
73. Name of Juror		74. Name of Juror		75. Name of Juror		76. Name of Juror	
None		None		None		None	
77. Name of Juror		78. Name of Juror		79. Name of Juror		80. Name of Juror	
None		None		None		None	
81. Name of Juror		82. Name of Juror		83. Name of Juror		84. Name of Juror	
None		None		None		None	
85. Name of Juror		86. Name of Juror		87. Name of Juror		88. Name of Juror	
None		None		None		None	
89. Name of Juror		90. Name of Juror		91. Name of Juror		92. Name of Juror	
None		None		None		None	
93. Name of Juror		94. Name of Juror		95. Name of Juror		96. Name of Juror	
None		None		None		None	
97. Name of Juror		98. Name of Juror		99. Name of Juror		100. Name of Juror	
None		None		None		None	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11946

Items 2, 2, 14. See: Birth Cert. et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>11961 Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wic.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury Md</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS <b>12 Patrick Ave</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Andre Carlile Barkley</b>		4. DATE OF DEATH Month <b>10-8-59</b> Day <b>19</b> Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1959</b>
9. AGE (In years last birthday) <b>1</b> yrs. <b>11</b> Months <b>11</b> Days		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Salisbury Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>McKinley Barkley</b>		14. MOTHER'S MAIDEN NAME <b>Alberta Barkley L. Veney</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>12 Patrick Alberta Barkley</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Asphyxia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
DUE TO <b>9210</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) <b>Aspiration of vomitus</b> <b>Sudden</b>
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Malnutrition</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found dead in bed.</b>	
20c. TIME OF INJURY Month, Day, Year <b>1:50 P.M. 10-8-59</b>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20e. (City or town) <b>Salisbury</b>		(County) <b>Wicomico</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		10-13-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-14-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Acres An</b>		22d. LOCATION (City, town, or county) <b>Salisbury Md</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Broken West</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>OCT 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Rumba</b>	

2291200

[illegible]

<div style="display: flex; justify-content: space-between;"> <span>Item 18 Film 250 10-27-59</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18</span> <span>11947</span> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;"> MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>													
<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Wicomico</span> <span style="float: right;">MARYLAND</span>						<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="font-size: 1.2em;">Wicomico</span>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Salisbury</span>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">12 Salisbury</span>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">618 South Division St</span>						d. STREET ADDRESS <span style="font-size: 1.2em;">618 S. Division St</span>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <span style="font-size: 1.2em;">DONALD</span> Middle <span style="font-size: 1.2em;">ALBRO</span> Last <span style="font-size: 1.2em;">BEACH</span>						<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">OCTOBER</span> Day <span style="font-size: 1.2em;">17th</span> Year <span style="font-size: 1.2em;">19 59</span>							
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>		<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">White</span>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">June 6, 1907</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">52 yrs.</span>		<b>IF UNDER 1 YEAR</b> Months <span style="font-size: 1.2em;">4</span> Days <span style="font-size: 1.2em;">11</span>		<b>IF UNDER 24 HRS.</b> Hours <span style="font-size: 1.2em;">11</span> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired Auto Parts-Employee</span>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">MAXX, Holland, Mich.</span>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U S A</span>			
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Harry A. Beach</span>						<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Mabel Siggins</span>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, say or unknown) <span style="font-size: 1.2em;">No</span> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mrs. Maude E. Beach (Wife) R.D. # Schumaker Road Salisbury, Maryland</span>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]													
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  IMMEDIATE CAUSE (a) <span style="font-size: 1.2em;">420.1</span> <span style="font-size: 1.2em;">Coronary occlusion</span>  DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <span style="font-size: 1.2em;">Sudden</span>  DUE TO (b) _____  DUE TO (c) _____ </div> <div style="width: 35%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <span style="font-size: 1.2em;">Sudden</span> </div> </div>													
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <span style="font-size: 1.2em;">19</span> o. m. p. m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.2em;">Earl L. Royer</span> <span style="float: right;">M.D.</span>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>							
<b>EXAMINER'S NAME (Type)</b> <span style="font-size: 1.2em;">Dr. Earl L. Royer</span>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>							
						<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>				<b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">Oct. 20, 1959</span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Pollitt's Family Cemetery</span>				<b>22d. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">R.D. # Schumaker Road Salisbury, Maryland</span>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">HOLLOWAY &amp; COMPA NY</span>						<b>ADDRESS</b> <span style="font-size: 1.2em;">SALISBURY, MARYLAND</span>		<b>24a. REC'D BY REGISTRAR</b> <span style="font-size: 1.2em;">OCT 20 '59</span>		<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">Arthur L. Kraus</span>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED J. Edgar Hoover		DATE OF DEATH June 5, 1963	
AGE 59		SEX Male	
RACE White		EDUCATION High School	
OCCUPATION Director, Federal Bureau of Investigation		RESIDENCE Washington, D.C.	
PLACE OF DEATH Washington, D.C.		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		IMMEDIATE CAUSE OF DEATH Myocardial Infarction	
PREVAILING DISEASES Coronary Artery Disease		OTHER DISEASES None	
SIGNS AND SYMPTOMS Chest pain, shortness of breath		TREATMENT None	
HISTORY No recent travel, no known allergies		FAMILY HISTORY None	
SOCIAL HISTORY No smoking, no alcohol		LABORATORY TESTS None	
PATHOLOGICAL FINDINGS None		MICROSCOPIC FINDINGS None	
GROSS FINDINGS None		HISTOCHEMICAL FINDINGS None	
TOXICOLOGICAL FINDINGS None		OTHER FINDINGS None	
SIGNATURE OF EXAMINER J. Edgar Hoover		DATE June 5, 1963	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11948

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>11963</b> <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Salisbury (Rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Dalton</b> Middle <b>Vance</b> Last <b>Brittingham</b> Jr.		4. DATE OF DEATH Month <b>10</b> Day <b>22</b> Year <b>59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1959</b>
9. AGE (In years last birthday) <b>6</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Dalton Vance Brittingham, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Beatrice Willey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>Address RD #3</b>	
17. INFORMANT <b>Dalton V. Brittingham, Sr. Salisbury, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>925.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Child found smothered with plastic bag.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>11:15</b> a. m. <b>10-22-59</b>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Own home.</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Salisbury</b>		20f. (City or town) (County) (State) <b>Wicomico Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 24, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hebron Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Georgetown (County) Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William L. ...</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 26 '59</b>	
ADDRESS <b>Georgetown, Del.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH-DEATH RECORD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF DEATH [REDACTED]		5. TIME OF DEATH [REDACTED]		6. PLACE OF DEATH [REDACTED]	
7. CAUSE OF DEATH [REDACTED]		8. MANNER OF DEATH [REDACTED]		9. MEDICAL HISTORY [REDACTED]	
10. PRESENT ILLNESS [REDACTED]		11. TREATMENT [REDACTED]		12. OTHER INFORMATION [REDACTED]	
13. SIGNATURE OF MEDICAL EXAMINER [REDACTED]		14. SIGNATURE OF REGISTRAR [REDACTED]		15. SIGNATURE OF WITNESS [REDACTED]	
16. DATE OF SIGNATURE [REDACTED]		17. TIME OF SIGNATURE [REDACTED]		18. PLACE OF SIGNATURE [REDACTED]	
19. SIGNATURE OF DECEASED [REDACTED]		20. SIGNATURE OF NEXT OF KIN [REDACTED]		21. SIGNATURE OF SURVIVOR [REDACTED]	
22. SIGNATURE OF SURVIVOR [REDACTED]		23. SIGNATURE OF SURVIVOR [REDACTED]		24. SIGNATURE OF SURVIVOR [REDACTED]	
25. SIGNATURE OF SURVIVOR [REDACTED]		26. SIGNATURE OF SURVIVOR [REDACTED]		27. SIGNATURE OF SURVIVOR [REDACTED]	
28. SIGNATURE OF SURVIVOR [REDACTED]		29. SIGNATURE OF SURVIVOR [REDACTED]		30. SIGNATURE OF SURVIVOR [REDACTED]	
31. SIGNATURE OF SURVIVOR [REDACTED]		32. SIGNATURE OF SURVIVOR [REDACTED]		33. SIGNATURE OF SURVIVOR [REDACTED]	
34. SIGNATURE OF SURVIVOR [REDACTED]		35. SIGNATURE OF SURVIVOR [REDACTED]		36. SIGNATURE OF SURVIVOR [REDACTED]	
37. SIGNATURE OF SURVIVOR [REDACTED]		38. SIGNATURE OF SURVIVOR [REDACTED]		39. SIGNATURE OF SURVIVOR [REDACTED]	
40. SIGNATURE OF SURVIVOR [REDACTED]		41. SIGNATURE OF SURVIVOR [REDACTED]		42. SIGNATURE OF SURVIVOR [REDACTED]	
43. SIGNATURE OF SURVIVOR [REDACTED]		44. SIGNATURE OF SURVIVOR [REDACTED]		45. SIGNATURE OF SURVIVOR [REDACTED]	
46. SIGNATURE OF SURVIVOR [REDACTED]		47. SIGNATURE OF SURVIVOR [REDACTED]		48. SIGNATURE OF SURVIVOR [REDACTED]	
49. SIGNATURE OF SURVIVOR [REDACTED]		50. SIGNATURE OF SURVIVOR [REDACTED]		51. SIGNATURE OF SURVIVOR [REDACTED]	
52. SIGNATURE OF SURVIVOR [REDACTED]		53. SIGNATURE OF SURVIVOR [REDACTED]		54. SIGNATURE OF SURVIVOR [REDACTED]	
55. SIGNATURE OF SURVIVOR [REDACTED]		56. SIGNATURE OF SURVIVOR [REDACTED]		57. SIGNATURE OF SURVIVOR [REDACTED]	
58. SIGNATURE OF SURVIVOR [REDACTED]		59. SIGNATURE OF SURVIVOR [REDACTED]		60. SIGNATURE OF SURVIVOR [REDACTED]	
61. SIGNATURE OF SURVIVOR [REDACTED]		62. SIGNATURE OF SURVIVOR [REDACTED]		63. SIGNATURE OF SURVIVOR [REDACTED]	
64. SIGNATURE OF SURVIVOR [REDACTED]		65. SIGNATURE OF SURVIVOR [REDACTED]		66. SIGNATURE OF SURVIVOR [REDACTED]	
67. SIGNATURE OF SURVIVOR [REDACTED]		68. SIGNATURE OF SURVIVOR [REDACTED]		69. SIGNATURE OF SURVIVOR [REDACTED]	
70. SIGNATURE OF SURVIVOR [REDACTED]		71. SIGNATURE OF SURVIVOR [REDACTED]		72. SIGNATURE OF SURVIVOR [REDACTED]	
73. SIGNATURE OF SURVIVOR [REDACTED]		74. SIGNATURE OF SURVIVOR [REDACTED]		75. SIGNATURE OF SURVIVOR [REDACTED]	
76. SIGNATURE OF SURVIVOR [REDACTED]		77. SIGNATURE OF SURVIVOR [REDACTED]		78. SIGNATURE OF SURVIVOR [REDACTED]	
79. SIGNATURE OF SURVIVOR [REDACTED]		80. SIGNATURE OF SURVIVOR [REDACTED]		81. SIGNATURE OF SURVIVOR [REDACTED]	
82. SIGNATURE OF SURVIVOR [REDACTED]		83. SIGNATURE OF SURVIVOR [REDACTED]		84. SIGNATURE OF SURVIVOR [REDACTED]	
85. SIGNATURE OF SURVIVOR [REDACTED]		86. SIGNATURE OF SURVIVOR [REDACTED]		87. SIGNATURE OF SURVIVOR [REDACTED]	
88. SIGNATURE OF SURVIVOR [REDACTED]		89. SIGNATURE OF SURVIVOR [REDACTED]		90. SIGNATURE OF SURVIVOR [REDACTED]	
91. SIGNATURE OF SURVIVOR [REDACTED]		92. SIGNATURE OF SURVIVOR [REDACTED]		93. SIGNATURE OF SURVIVOR [REDACTED]	
94. SIGNATURE OF SURVIVOR [REDACTED]		95. SIGNATURE OF SURVIVOR [REDACTED]		96. SIGNATURE OF SURVIVOR [REDACTED]	
97. SIGNATURE OF SURVIVOR [REDACTED]		98. SIGNATURE OF SURVIVOR [REDACTED]		99. SIGNATURE OF SURVIVOR [REDACTED]	
100. SIGNATURE OF SURVIVOR [REDACTED]		101. SIGNATURE OF SURVIVOR [REDACTED]		102. SIGNATURE OF SURVIVOR [REDACTED]	

RECEIVED  
JAN 10 1963  
MASSACHUSETTS DEPARTMENT OF HEALTH  
BIRTH-DEATH RECORD



STATE OF TEXAS  
COUNTY OF DALLAS

1904

I, the undersigned, Clerk of the County of Dallas, State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Dallas, State of Texas, and that the same is a true and correct copy of the original as the same appears in the records of the County of Dallas, State of Texas.

Witness my hand and the seal of the County of Dallas, State of Texas, this 1st day of January, 1904.

Clerk of the County of Dallas, State of Texas.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11950

11965

Item 7 Film 250 10-16-59 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Moses</b> Middle <b>Bunting</b> Last <b>Bunting</b>		4. DATE OF DEATH Month <b>10</b> Day <b>10</b> Year <b>59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 11<sup>th</sup> 1895</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months <b>70</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Accomack County, VA</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Bunting</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Victor Bunting</b>		Address <b>Fruitland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured cervical spine</b> 822x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Passenger in car that ran off road and turned over.</b>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month <b>10</b> Day <b>10</b> Year <b>59</b> Hour <b>5</b> P.M.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> al work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Back road.</b>	
20f. (City or town) <b>Eden</b>		(County) <b>Wicomico</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>10-11-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 18, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Shiloh Baptist</b>		22d. LOCATION (City, town, or county) (State) <b>Painter, R.F.D. (Boston) Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar Thomas</b>		ADDRESS <b>Some, Accomack, Va.</b>	
24a. REC'D BY REGISTRAR <b>OCT 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10-10-90 BY 60322 UCBAW/STP

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## CERTIFICATE OF DEATH

Reg. Dist. No.

11966

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>704 E. Church St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LYDIA</b> Middle <b>MAE</b> Last <b>BURBAGE</b>		4. DATE OF DEATH Month <b>October</b> Day <b>6</b> th 19 <b>59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 18, 1904</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>18</b>	11. IF UNDER 24 HRS. Hours <b>18</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Parsenburg, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>William H. Timmons</b>	
14. MOTHER'S MAIDEN NAME <b>Jane Parsons</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>INFORMANT</b>		17. ADDRESS <b>Mr. Edward W. Burbage (Husband) 704 E. Church St Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>coronary atheromatosis</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>hypertension, essential</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>2</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>9-18</b> , 19 <b>57</b> , to <b>10-8</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10-2</b> , 19 <b>57</b> , and that death occurred at <b>2:15</b> P. M. from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>R. V. Sohler</b> M.D.		DATE SIGNED <b>Oct. 8 / 1959</b>	
PHYSICIAN'S NAME (Type) <b>Dr. L. V. Sohler</b>		ADDRESS <b>Delmar, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-</b>	22b. DATE THEREOF <b>Oct. 9, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Mem. Park</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>OCT 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11952

11967

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b> <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Catherine Carter</b>		4. DATE OF DEATH <b>10-31-59</b> <b>19</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 2, 1990</b> <b>39</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Florida</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
13. FATHER'S NAME <b>James Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Roberson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>916</b>	
17. INFORMANT <b>Joshua Wilson</b> Address <b>493 Rardin ave. Oakdale Florida</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shot gun wound of abdomen</b> 981X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>981X</b> (c), stating the underlying cause lost. (c) <b>981X</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>981X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot by John Wilkes at 111 Lake St. Salisbury, Md.</b>	
20c. TIME OF INJURY Month, Day, Year <b>7:40 P.M. 10-31-59</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>The Spot-Bar, Salisbury</b>		20f. (City or town) (County) (State) <b>Salisbury Wicomico Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>11-3-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/7/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Olives</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clinton F. Stewart</b>		ADDRESS <b>Salisbury Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Clara P. Hanes</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED

RESIDENCE

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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## CERTIFICATE OF DEATH

Reg. Dist. No.

11968

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>12</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jesse THOMAS CARTWRIGHT</u>		4. DATE OF DEATH <u>October 9, 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 20, 1919</u>
9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM WALTER CARTWRIGHT</u>		14. MOTHER'S MAIDEN NAME <u>AMY FRANCES BROWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WORLD WAR 2</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>313 FRONT ST OCEANIA, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>490X</u> <u>Lobar pneumonia</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/8</u> , 19 <u>59</u> , to <u>10/9</u> , 19 <u>59</u> that I last saw the deceased alive on <u>10/9</u> , 19 <u>59</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry Mattax</u>		ADDRESS (Street, city or town, state) <u>711 CAMDEN AVE</u>	
PHYSICIAN'S NAME (Type) <u>HARRY MATTAX, M.D.</u>		DATE SIGNED _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10-12-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CHARITY CHURCH CEME</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCESS ANNE Co. VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hollomon Brown - C. Mayo</u>		24a. REC'D BY REGISTRAR <u>NORFOLK, VIRGINIA</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11987

*[Faint, illegible text, likely a death certificate form with fields for name, date, and location.]*

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11954

11969

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>12 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>N.</u> Last <u>CLARKE</u>		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/21/1891</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>16</u> Hours <u>15</u> Min.	11. IF UNDER 24 HRS. Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DRUGSTORE</u>	
11. BIRTHPLACE (State or foreign country) <u>POCOMOKE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARION T. CLARKE</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE MILLS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WAR #1</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>MRS. RUTH Y. CLARKE (POCOMOKE)</u>	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial Stenosis, bronchiectasis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1959</u> Hour <u>o. m.</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 16, 1958</u> to <u>Oct 16, 1959</u> , that I last saw the deceased alive on <u>Oct 16, 1959</u> , and that death occurred at <u>9:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u>		DATE SIGNED <u>Oct. 16, 1959</u>	
PHYSICIAN'S NAME (Type) <u>DAVID J. GILMORE</u>		ADDRESS (Street, city or town, state) <u>Salisbury Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/19/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BETHANY METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Watson Pocomoke, Md</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 21 1959</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton S. Perma</u>			

100

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G250 10-16-59 et

11955

11970

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>685 Fitzwater St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence</u> <u>CUSTIS</u>		4. DATE OF DEATH Month Day Year <u>October 5, 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Custis</u>		14. MOTHER'S MAIDEN NAME <u>Enia White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>301</u>	
17. INFORMANT <u>Willie Jones, Sypris St. Salisbury Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Embolism of Coronary Arteries</u> DUE TO <u>464X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Thrombophlebitis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 19, 1959</u> to <u>Oct 5, 1959</u> , that I last saw the deceased alive on <u>10/5/59</u> , 19, and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Carrie Hearn</u> M.D. <u>226 N. Remondin St</u>		<u>Salisbury Md</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES H E ARN.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/8/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>green acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>		24a. REC'D BY REGISTRAR <u>13 '59</u>	
ADDRESS <u>Salisbury Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hearn</u>	

11230

11230

1

## CERTIFICATE OF DEATH

Reg. Dist. No.

11956

11971

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> 23X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>PAUL MITCHELL DAVIS</u>				4. DATE OF DEATH Month Day Year <u>OCTOBER 15 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 24, 1908</u>		9. AGE (In years last birthday) <u>50</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICEMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TOWNS</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH H. DAVIS</u>				14. MOTHER'S MAIDEN NAME <u>ALICE MITCHELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-20-6698</u>		INFORMANT <u>MRS. P. M. DAVIS</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>8 days</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-7</u> , 19 <u>59</u> , to <u>10-15</u> , 19 <u>59</u> that I last saw the deceased alive on <u>10-15</u> , 19 <u>59</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Ellis</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>10-15-59</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/19/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Barbary</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR <u>OCT 20 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Orin L. Hume</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1950

CERTIFICATE OF DEATH

1950

1

Attest my hand and the seal of the State of New York, this 1st day of January, 1950.

Notary Public for the State of New York

## CERTIFICATE OF DEATH

Reg. Dist. No.

11957

11972

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>11 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SELBYVILLE</u> d. STREET ADDRESS <u>WILLIAMS STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PAUL</u> First <u>K.</u> Middle <u>DEBOER</u> Last 4. DATE OF DEATH <u>October 22</u> Month <u>1959</u> Year		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 14, 1907</u> 9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dry Goods</u>	
11. BIRTHPLACE (State or foreign country) <u>Montpelier Vt.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph A DeBoer</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Featherly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>World War 1 &amp; 2</u>		16. SOCIAL SECURITY NO. <u>009-09-5434</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fibrosarcoma of Lung, Metastatic</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>from Right forearm</u> DUE TO (c) <u>18 mos</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 11, 1959</u> to <u>Oct. 22, 1959</u> , that I last saw the deceased alive on <u>October 21, 1959</u> , and that death occurred at <u>2:00</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Pine Bluff Road Selbyville, Md.</u> DATE SIGNED <u>10/22/59</u>	
PHYSICIAN'S NAME (Type) <u>Thomas C. Hill, Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10/26/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Mountain</u>		22d. LOCATION (City, town, or county) (State) <u>Montpelier Vermont</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Katherine Thaler, Selbyville Del.</u>		24a. REC'D BY REGISTRAR <u>Oct 26 59</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11051

UNITED STATES DEPARTMENT OF JUSTICE

CRIMINAL DIVISION

1987

WITNESS

Testimony

Witness

Examination

Direct

1

On this day, I, the undersigned, being duly sworn, depose and say that the foregoing is a true and correct copy of the transcript of the testimony of the witness named above, as given in the case of the United States of America, against the defendant named above, on the day and at the place specified in the foregoing caption.

Subscribed and sworn to before me this day of the month of the year 1987.

Notary Public for the State of New York

Subscribed and sworn to before me this day of the month of the year 1987.

Notary Public for the State of New York

My Commission Expires on the day of the month of the year 1987.

Notary Public for the State of New York

My Commission Expires on the day of the month of the year 1987.

Notary Public for the State of New York

12012

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>ALFRED C. DENNIS</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>19</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 22, 1920</b>	9. AGE (In years last birthday) <b>39</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Willards</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ray Dennis</b>				14. MOTHER'S MAIDEN NAME <b>Lillie Dennis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>213-12-5499</b>		17. INFORMANT Address <b>Mrs. Hilda Dennis Willards, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary carcinoma metastasizing</b> 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 1959</b> , to <b>10-19</b> , 1959, that I last saw the deceased alive on <b>10-19</b> , 1959, and that death occurred at <b>2:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Frank Lewis</b> M.D. <b>Willards Maryland</b> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/21/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dennis</b>		22d. LOCATION (City, town, or county) (State) <b>Willards, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Peter Whaley Selbyville, Del.</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

18042

MAINTAINED STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1. NAME OF DECEASED ALFRED		2. SEX MALE	
3. AGE 45		4. DATE OF BIRTH JAN 15 1859	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION CLOCKMAKER	
7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE JUN 10 1885	
9. NAME OF SPOUSE MRS. ALFRED		10. DATE OF DEATH JAN 15 1904	
11. PLACE OF DEATH BALTIMORE, MARYLAND		12. CAUSE OF DEATH HEART DISEASE	
13. TIME OF DEATH 10:30 AM		14. SIGNATURE OF PHYSICIAN J. H. [Signature]	
15. SIGNATURE OF WITNESS [Signature]		16. SIGNATURE OF REGISTRAR [Signature]	
17. NAME OF REGISTRAR J. H. [Signature]		18. OFFICE OF REGISTRAR BALTIMORE, MARYLAND	
19. DATE OF REGISTRATION JAN 15 1904		20. PLACE OF REGISTRATION BALTIMORE, MARYLAND	

1. NAME OF DECEASED  
ALFRED

2. SEX  
MALE

3. AGE  
45

4. DATE OF BIRTH  
JAN 15 1859

5. PLACE OF BIRTH  
BALTIMORE, MARYLAND

6. OCCUPATION  
CLOCKMAKER

7. MARITAL STATUS  
MARRIED

8. DATE OF MARRIAGE  
JUN 10 1885

9. NAME OF SPOUSE  
MRS. ALFRED

10. DATE OF DEATH  
JAN 15 1904

11. PLACE OF DEATH  
BALTIMORE, MARYLAND

12. CAUSE OF DEATH  
HEART DISEASE

13. TIME OF DEATH  
10:30 AM

14. SIGNATURE OF PHYSICIAN  
J. H. [Signature]

15. SIGNATURE OF WITNESS  
[Signature]

16. SIGNATURE OF REGISTRAR  
[Signature]

17. NAME OF REGISTRAR  
J. H. [Signature]

18. OFFICE OF REGISTRAR  
BALTIMORE, MARYLAND

19. DATE OF REGISTRATION  
JAN 15 1904

20. PLACE OF REGISTRATION  
BALTIMORE, MARYLAND

11973

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsular General Hospital</u>		d. STREET ADDRESS <u>314 Cherry Way</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ESTELLE</u> Middle <u>MAE</u> Last <u>Dennis</u>		4. DATE OF DEATH Month <u>October</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9, 1889</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>	IF UNDER 24 HRS. Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Phila, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John Wesley Marley</u>		14. MOTHER'S MAIDEN NAME <u>Alice Emma Long</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>Mr. Virgil W. Dennis (Husband) 314 Cherry Way (P.O.B.#24) Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-3</u> , 19 <u>59</u> , to <u>10-15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-15</u> , 19 <u>59</u> , and that death occurred at <u>9:30</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. R. Ellis Jr.</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>10-15-59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Wilber R. Ellis Jr.</u>		Medical Center- Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 19, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cem. Co. Suitland, Maryland</u>	22d. LOCATION (City or town, state) <u>Washington 20 D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>OCT 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES OF AMERICA

11923

Washington, D.C.

July 1950

Mr. J. Edgar Hoover

Director, FBI

Dear Mr. Hoover:

Enclosed

is one copy

of a letterhead memorandum dated and captioned as above.

Very truly yours,

Special Agent in Charge, New York Office

Enclosure

11974

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> 23X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VINCENT</u> Middle <u>W.</u> Last <u>DENNIS</u>		4. DATE OF DEATH Month <u>October</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years lost birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TIRE Co</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN DENNIS</u>		14. MOTHER'S MAIDEN NAME <u>NETTIE BRITTINGHAM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WORLD WAR 2</u>		16. SOCIAL SECURITY NO. <u>219-12-8106</u>	
INFORMANT Address <u>MRS NETTIE DENNIS BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>previous myocardial infarction</u> DUE TO (c) <u>Coronary artery disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>6 mos.</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> to <u>Oct. 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct. 8</u> , 19 <u>59</u> , and that death occurred at <u>11:47 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert G. Grubb MD</u> M.D.		ADDRESS (Street, city or town, state) <u>BERLIN, MD.</u> DATE SIGNED <u>10/8/59</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT A. GRUBB, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10/11/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burdette</u> ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11-17-19

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12013

## CERTIFICATE OF DEATH

11962

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Wico.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHARPTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOMEL</u>		d. STREET ADDRESS <u>MARDELA R.F.D. 1</u>	
3. NAME OF DECEASED (Type or print) <u>RHUEL</u> First <u>E.</u> Middle <u>GOSLEE</u> Last		4. DATE OF DEATH <u>OCTOBER 31</u> 19 <u>59</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COL.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 16, 1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES E. GOSLEE</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE G. BROWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-10-8604</u>	
17. INFORMANT <u>MARTHA GOSLEE MARDELA</u> Address <u>R.F.D. 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetic mellitus</u> DUE TO (c) <u>Arteriosclerosis (Cerebral Vascular Disease)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>MD.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1</u> , 19 <u>59</u> , to <u>Oct 31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 31</u> , 19 <u>59</u> , and that death occurred at <u>4P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Charles M. Moyer</u> M.D.		PHYSICIAN'S NAME (Type) <u>Charles M. Moyer</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>NOV. 5, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ZION-CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SHARPTOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u> ADDRESS <u>Salisbury Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 10 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1901

DATE OF DEATH

DECEASED

RESIDENT

PLACE OF DEATH

W. COVINGTON

ST. JOHN

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W. H. H.

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W. H. H.

## CERTIFICATE OF DEATH

Reg. Dist. No.

11963

11975

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>X</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springhill Sanitarium</b>		d. STREET ADDRESS <b>Route 50</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edwin Derrickson Harrington</b>		4. DATE OF DEATH Month Day Year <b>October 8, 1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 5, 1894</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>Frank Harrington</b>		14. MOTHER'S MAIDEN NAME <b>Isadore Pritchett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>War 1</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Pauline Humphreys: Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7/10</b> , 19 <b>58</b> , to <b>10/8/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10/7</b> , 19 <b>59</b> , and that death occurred at <b>8 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b> DATE SIGNED ACTUAL SIGNATURE <b>H. R. Dames</b> M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL, ETC. (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/11/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>John Wesley</b>	22d. LOCATION (City, town, or county) (State) <b>Mt. Vernon Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James L. Leman</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 16 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>

1

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11964
11976										CERTIFICATE OF DEATH
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>					c. LENGTH OF STAY IN 1b <b>12</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>308 N. Division St. (Crew-Mor Apts)</b>					d. STREET ADDRESS <b>308 N. Div. St. (Crew-Mor Apts)</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>ALICE</b> Last <b>HORNER</b>					4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>10th</b> Year <b>19 59</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 7, 1892</b>		9. AGE (In years last birthday) <b>67</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee-Shirt Factory-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Sussex Co. Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>				
13. FATHER'S NAME <b>Isaac Levin Foskey</b>					14. MOTHER'S MAIDEN NAME <b>Rosa Gertrude Truitt</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <b>INFORMANT Mrs. Lois H. Pusey (Daughter) 308 N. Div. St. (Crew-Mor Apts) Salisbury, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> <b>155.1</b> DUE TO <b>Carcinoma of Gall Bladder</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 mon 1 yr?</b>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>8:11</b> , 19 <b>59</b> , to <b>10:10</b> , 19 <b>59</b> that I last saw the deceased alive on <b>10.9.59</b> , 19 <b>59</b> , and that death occurred at <b>7:40P</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>October 12/59</b> ACTUAL SIGNATURE <b>HENRY A. BRIELE</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. William H. Fisher Jr.</b> Medical Center - Salisbury, Maryland										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>Oct. 13, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hebron Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Hebron, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>					24a. REC'D BY REGISTRAR DATE <b>OCT 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Truitt</b>			

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen Hospital</b>		e. STREET ADDRESS <b>R.D.# 3(Delmar Rd.)</b>	
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>R.</b> Last <b>HUETHER</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>7th</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1913</b>
9. AGE (In years last birthday) yrs. <b>46</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>15</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst. Manager-Swift &amp; Co.(D.&amp; P.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	11. BIRTHPLACE (State or foreign country) <b>U S A</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Conrad Huether</b>	
14. MOTHER'S MAIDEN NAME <b>Martha Rasmussen</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>INFORMANT</b>		17. ADDRESS <b>Mrs. Frances M. Huether (Wife) R.D.# 3 Delmar Rd. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>454X Atelectasis, bilateral, severe</b> DUE TO (b) <b>Multifocal emboli to kidneys, brain, lungs 2-3 days</b> DUE TO (c) <b>and st. communilic adenoys Sup. mediastinic artery</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b></b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10-1</b> , 19 <b>59</b> to <b>10-7</b> , 19 <b>59</b> that I last saw the deceased alive on <b>10-7</b> , 19 <b>59</b> , and that death occurred at <b>1:40P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b></b> DATE SIGNED <b>Oct. 8 /1959</b>			
ACTUAL SIGNATURE <b>William H. Fisher Jr.</b> M.D.		DATE SIGNED <b>Oct. 8 /1959</b>	
PHYSICIAN'S NAME (Type) <b>Dr. William H. Fisher Jr. Medical Center Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 10, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	24a. REC'D BY REGISTRAR DATE <b>OCT 13 '59</b>
24b. REGISTRAR'S SIGNATURE <b>Cecilus A. Knease</b>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4. The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4. The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11405

MASSACHUSETTS STATE DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH

REPORT OF



LABORATORY

RESULTS

TESTS

NO. 1 (SEROLOGY)

NO. 2 (SEROLOGY)

DATE OF TEST

DATE

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

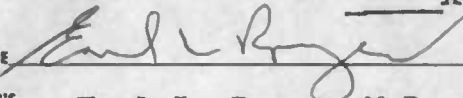

[Faint, mostly illegible text covering the lower half of the page, likely containing test results and patient information.]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11978 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11966

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>Route # 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jack</b> Middle <b>Jester</b> Last <b>Jester</b>				4. DATE OF DEATH Month <b>10</b> Day <b>27</b> Year <b>59</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 4 1942</b>		9. AGE (In years last birthday) <b>17</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT Kenneth JESTER</b>				14. MOTHER'S MAIDEN NAME <b>LIDA MAE BRASURE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>216-38-8802</b>		17. INFORMANT <b>LIDA MAE ROUNDS</b> Address <b>RD #2 Salisbury MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sub-dural hemorrhage-left.</b> <b>816X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in car involved in collision on Rt. # 313</b>					
20c. TIME OF INJURY Month, Day, Year <b>9:30 A.M. 10-24-59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt # 313</b>		20f. (City or town) (County) (State) <b>Mardela Wicomico Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE 				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>10-27-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>OCT. 29, 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST JOHN'S TOWN Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>GREENWOOD Dela.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY, MARY LAND</b>		24a. REC'D BY REGISTRAR <b>NOV 2 '59</b>	
				24b. REGISTRAR'S SIGNATURE 			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



11979

## CERTIFICATE OF DEATH

11967

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CARL</u> Middle <u>LEE</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>October</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6th 1987</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.	11. IF UNDER 24 HRS. Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Asst. Dist. Supt. (Prudential Life Ins Co.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mt. Vernon, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>George W. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Bloodsworth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT Mrs. Agnes Jones (Wife) Salisbury, Maryland</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>10 days</u> (c) <u>10 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/22</u> to <u>10/22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/22</u> , 19 <u>57</u> , and that death occurred at <u>Salisbury, Md.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. R. Gramse</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>Oct. 22, 1957</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Fred R. Gramse</u>		S. Division St. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 24, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. RECEIVED BY REGISTRAR <u>OCT 23 59</u>		DATE <u>OCT 23 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>		DATE <u>OCT 23 59</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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103-MA-3-114

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11968

Reg. Dist. No.

12014

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wetipquin</u>			c. LENGTH OF STAY IN 1b <u>Lifetime</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wetipquin</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle _____ Last <u>Jones</u>				<b>4. DATE OF DEATH</b> Month <u>10</u> Day <u>11</u> Year <u>59</u>						
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-11-81</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Oyster Tonger</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Samuel Jones</u>				14. MOTHER'S MAIDEN NAME <u>Sarah A. --</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>--</u>		17. INFORMANT <u>Orenzie Jones, Wetipquin, Md.</u>						
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASCD</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>Home</u> <u>year</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month, Day, Year <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED _____					
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-13-59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cem.</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Wetipquin, Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Pearson</u> ADDRESS <u>Bivalve, Maryland</u>					24a. REC'D BY REGISTRAR <u>Oct 16 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR  
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PHYSICIAN: The low  
hospital or attending pl  
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-1 within 24 hours after  
ely filled in by the  
Pages 1 and 2

11875

## CERTIFICATE OF DEATH

11879

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>105 N 8th St</u>	
3. NAME OF DECEASED (Type or print) First <u>Milton</u> Middle <u>E.</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>October</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 13-1888</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		IF UNDER 1 YEAR: Months <u>8</u> Days <u>8</u> Hours <u>8</u> Min. <u>8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Physician Neurologist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medicine, MD</u>	
11. BIRTHPLACE (State or foreign country) <u>Chillicothe, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thompson Jones</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Smack</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>World War I</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Ruth A. Jones</u> Address <u>Ocean City, MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degenerative Heart Disease</u> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>unlabeled</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-20-1958</u> , to <u>10-21-1958</u> , that I last saw the deceased alive on <u>10-21-1958</u> , and that death occurred at <u>4:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Ellis, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, MD</u> DATE SIGNED <u>10-21-58</u>	
PHYSICIAN'S NAME (Type) <u>William R. Ellis, Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Oct 23/58</u>		22b. DATE THEREOF <u>Oct 23/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chillicothe, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton E. Harris</u> ADDRESS <u>Snow Hill, MD</u>		24a. REC'D BY REGISTRAR <u>Oct 23 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

MEDICAL CERTIFICATION

page 3 should be attached to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

See birth certificate on file

11969

11980

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 PENINSULA General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM HOWARD JONES</u>				4. DATE OF DEATH Month Day Year <u>October 13, 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 12, 1959</u>	
9. AGE (In years last birthday) <u>- yrs.</u>		10. AGE (In years last birthday) <u>- yrs.</u>		11. AGE (In years last birthday) <u>- yrs.</u>		12. AGE (In years last birthday) <u>- yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>Wicomico Co., Md.</u>			
13. FATHER'S NAME <u>HOWARD L. JONES</u>				14. MOTHER'S MAIDEN NAME <u>Madeline Esther Winder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO. <u>Mother</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Atelectasis</u> DUE TO (b) <u>Prematurity (Birth wt. 1340 gms)</u> DUE TO (c) <u>8810 x 1 1/2 hrs</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10/12</u> , 19 <u>59</u> , to <u>10/13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/13</u> , 19 <u>59</u> , and that death occurred at <u>5:45</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alfred C. Koller</u> M.D.				ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>10/13/59</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>October 13, 1959 John Wesley</u>				22b. DATE THEREOF <u>October 13, 1959</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico</u>				22d. LOCATION (City, town, or county) (State) <u>Wicomico Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Father Howard L. Jones</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 16 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

11980

WEST VIRGINIA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

11980

*[Faint, mostly illegible text, likely a death certificate form with fields for name, date, and cause of death.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11981

## CERTIFICATE OF DEATH

Reg. Dist. No.

11970

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>10 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Hill Pr. Sani.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MAGGIE GRAYCE KNUDSON</b>		4. DATE OF DEATH <b>10 14 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1885</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>	
11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hans Ferbitz</b>		14. MOTHER'S MAIDEN NAME <b>Christine Sorenson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>483-09-4101</b>	
17. INFORMANT <b>Mr. Benjamin F. Knudson, Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442x Cardiovascular Rinal Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 yr.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1959</b> to <b>12-14 1959</b> , that I last saw the deceased alive on <b>12-13 1959</b> and that death occurred at <b>11:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>10/16/59</b>			
ACTUAL SIGNATURE <b>Philip A. Insley</b> M.D. <b>Salisbury, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Philip A. Insley East Main St., Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-17-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>		24a. REC'D BY REGISTRAR <b>1959</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

Norman T. Baker

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		SEX Male	
AGE 30 years		DATE OF BIRTH 1900	
PLACE OF BIRTH Maryland		OCCUPATION Farmer	
MARITAL STATUS Single		CAUSE OF DEATH Heart Disease	
DATE OF DEATH 1919		PLACE OF DEATH Home	
SIGNATURE OF DECEASED (Blank)		SIGNATURE OF WITNESSES (Blank)	
SIGNATURE OF PHYSICIAN (Blank)		SIGNATURE OF CLERK (Blank)	
SIGNATURE OF MINISTER (Blank)		SIGNATURE OF JURY (Blank)	
SIGNATURE OF CORONER (Blank)		SIGNATURE OF JUDGE (Blank)	
SIGNATURE OF SHERIFF (Blank)		SIGNATURE OF TOWNSHIP CLERK (Blank)	
SIGNATURE OF COUNTY CLERK (Blank)		SIGNATURE OF STATE CLERK (Blank)	



1919

1

## CERTIFICATE OF DEATH

11971

11982

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Powershurst</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Willards</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Nichols Nursing Home</i>		f. STREET ADDRESS <i>R. F. D.</i>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>E.</i> Last <i>Leicester</i>		4. DATE OF DEATH Month <i>10</i> Day <i>14</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/4/1872</i>
9. AGE (In years last birthday) <i>87</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>Del.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Alexander Leicester</i>		14. MOTHER'S MAIDEN NAME <i>Isabell Rickets</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Oliver Leicester - Frankford - Del.</i>	
17. INFORMATION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular accident</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive C.V. Disease</i> DUE TO (c) <i>aging process</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 10, 1959</i> to <i>10/14, 1959</i> , that I last saw the deceased alive on <i>10/12, 1959</i> , and that death occurred at <i>4 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. B. Smith</i> M.D.		DATE SIGNED <i>10/16/59</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/17/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mechanics Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Willards - Del.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ronald James - Millsboro - Del.</i>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	
DATE <i>OCT 19 59</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
12015 CERTIFICATE OF DEATH									
Reg. Dist. No. 11972									
1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Center St</b>					d. STREET ADDRESS <b>Center St</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>(Adell) XADELL</b> First <b>LOUISE</b> Middle <b>MARTIN</b> Last					4. DATE OF DEATH Month <b>OCT.</b> Day <b>9th</b> Year <b>1959</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 22, 1882</b>		9. AGE (In years last birthday) yrs. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Eden, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Solomon Willey</b>					14. MOTHER'S MAIDEN NAME <b>Maiz J. Kelley</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mr. Oscar P. Martin (Son) Lakeside Manor Laurel, Delaware</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332x Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>generalized arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>? years</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>FRACTURE, Femur, Right - 2 Aug 59</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>August 8, 1959</b> , to <b>Oct. 9, 1959</b> , that I lost saw the deceased alive on <b>Oct. 6, 1959</b> , and that death occurred at <b>10 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Oct. 10/1959</b>									
ACTUAL SIGNATURE <b>Robert T. Adkins</b> M.D.									
PHYSICIAN'S NAME (Type) <b>Dr. Robert T. Adkins</b>					Fruitland, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Oct. 12, 1959</b>			22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>					ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Thoma</b>



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11983

CERTIFICATE OF DEATH

Reg. Dist. No.

11973

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED First Middle Last <u>Charles Thomas</u> <u>Mears</u>				4. DATE OF DEATH Month Day Year <u>October</u> <u>14</u> <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 13 - 1892</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Parkley, Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>William Thomas Mears</u>				14. MOTHER'S MAIDEN NAME <u>Leah Townsend</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-32-0747</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>39</u> to <u>Oct 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 13</u> , 19 <u>59</u> , and that death occurred at <u>1:30</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Seltman</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>10/14/59</u>			
PHYSICIAN'S NAME (Type) <u>David J. Seltman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Oct 17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>May &amp; Son</u> ADDRESS <u>Snow Hill, Md</u>				24a. REC'D BY REGISTRAR <u>Oct 19 59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>	

100-111111

11983

UNITED STATES OF AMERICA

11983

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 11974									
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eden (Rural)</b> c. LENGTH OF STAY IN 1b <b>Eden (Rural)</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.D.#</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eden (Rural)</b> d. STREET ADDRESS <b>R.D.#</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>CLEVELAND</b> Last <b>MEARS</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>4th</b> Year <b>19 59</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 25, 1889</b>		9. AGE (In years last birthday) <b>69</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Building</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Eugene Mears</b>		14. MOTHER'S MAIDEN NAME <b>Georginna Showard</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>Mr. Charles C. Mears Jr. (Son) R.D.#</b>		17. INFORMANT <b>Eden, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardio-vascular disease</b> <b>581.0</b> DUE TO <b>Cirrhosis of liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>581.0</b> DUE TO <b>Cirrhosis of liver</b> (c) <b>581.0</b> DUE TO <b>Cirrhosis of liver</b> INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>581.0</b> DUE TO <b>Cirrhosis of liver</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>October 6 1959</b>					
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 7- /59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton J. Hume</b>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **11975**

**11984**

<b>1. PLACE OF DEATH</b> o. COUNTY <u>Maryland</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pen. Gen. Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Showell</u> d. STREET ADDRESS <u>In Village</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>FRANK</u> Middle <u>ALFRED</u> Last <u>MELSON</u>		<b>4. DATE OF DEATH</b> Month <u>OCTOBER</u> Day <u>25</u> Year <u>19 59</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>July 3, 1910</u>
<b>9. AGE</b> (In years last birthday) <u>49</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Service Station Manager (Cities Serv.)</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>R.D.# Pittsville, Md</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>U S A</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U S A</u>	
<b>13. FATHER'S NAME</b> <u>John Handy Melson</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Laura Alice Workman</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>INFORMANT Mrs. Wilsie Catherine Melson (Wife) Showell, Maryland</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mycocardial infarction, Acute Anterior</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mycocardial Insufficiency</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that I attended the deceased from</b> <u>10/16</u> , 19 <u>59</u> , <b>to</b> <u>10/25</u> , 19 <u>59</u> , <b>that I last saw the deceased alive on</b> <u>10/24</u> , 19 <u>59</u> , <b>and that death occurred at</b> <u>1:00A</u> <b>PM</b> , <b>from the causes and on the date stated above.</b> <b>ACTUAL SIGNATURE</b> <u>Rufus S. Gardner Jr.</u> <b>M.D.</b> <u>Pine Bluff Rd. Salisbury, Maryland</u> <b>DATE SIGNED</b> <u>October 26 /1959</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Oct. 27, 1959</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Line Church Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>R.D.# Pittsville, Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HOLLOWAY &amp; COMPANY</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE OCT 28 '59</u>	
<b>ADDRESS</b> <u>SALISBURY, MARYLAND</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>  </u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12011

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11985

CERTIFICATE OF DEATH

Reg. Dist. No.

11976

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion RFD</b> <b>19X-2</b>		d. STREET ADDRESS <b>RFD 1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Dona</b> Middle <b>Lee</b> Last <b>Mister</b>		4. DATE OF DEATH Month <b>October</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/27/1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Howard</b>		14. MOTHER'S MAIDEN NAME <b>Mary Tull</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Deer's Head Hospital Records</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b> <b>422.1</b> DUE TO <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Yrs</b> (c) <b>Ca. of large bowels with metastasis</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 5</b> , 19 <b>59</b> , to <b>Oct. 7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct. 7</b> , 19 <b>59</b> , and that death occurred at <b>2:00A-M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>L. V. Maldve, M. D.</b> DATE SIGNED <b>10/7/59</b> ACTUAL SIGNATURE <b>L. V. Maldve, M. D.</b> M.D. <b>Deer's Head Hospital; Salisbury, Md.</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-10-59</b>	
22c. NAME OF CEMETERY <b>Rehobeth Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Rehobeth, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry B. Watson</b>		24a. REC'D BY REGISTRAR <b>OCT 13 '59</b>	
ADDRESS <b>Pocomoke City, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>	

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95-01-04 10-10-00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11986

CERTIFICATE OF DEATH

Reg. Dist. No. 11977

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>Accomac</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>83X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George William Mister</u>		4. DATE OF DEATH Month Day Year <u>October 6 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/22/1903</u>
9. AGE (In years lost birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Tilton Mister</u>		14. MOTHER'S MAIDEN NAME <u>Andrew D. Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>225-18-6606</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u>		ADDRESS (Street, city or town, state) <u>Salisbury Md</u>	
PHYSICIAN'S NAME (Type) <u>For Funeral Home</u>		DATE SIGNED <u>10/6/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/8/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mister Ceme.</u>		22d. LOCATION (City, town, or county) (State) <u>SAXIS VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>For Funeral Home</u>		24. REGISTRAR'S SIGNATURE <u>Christina S. Kline</u>	

24a. REC'D BY REGISTRAR  
DATE OCT 14 '59

Virginia

MANUSCRIPT ACCEPTED

1  
TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11987

## CERTIFICATE OF DEATH

Reg. Dist. No. 11978

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Delmar</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hospital</b>		1. d. STREET ADDRESS <b>East St.</b>	
3. NAME OF DECEASED (Type or print) <b>THOMAS</b> <b>MITCHELL</b>		4. DATE OF DEATH <b>OCTOBER 28th 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED X</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 21, 1884</b>
9. AGE (In years lost birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter- House Construction</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Employee Whitesville, Del.</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Elijah J. Mitchell</b>		14. MOTHER'S MAIDEN NAME <b>Julia Parsons</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mr. Melvin Bratten (Nephew) 202 Maryland Ave. Salisbury Delmar, Delaware</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>332X</b> <b>Cerebral Arteriosclerosis with thrombosis</b> IMMEDIATE CAUSE (a) <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>DUE TO</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of Lung</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____ and that death occurred at _____ M, from the causes and on the date stated above. <b>David J. Gilmore</b> <b>Salisbury Md</b> <b>Oct. 30/1959</b> ACTUAL SIGNATURE <b>Dr. David J. Gilmore</b> <b>Medical Center Salisbury, Maryland</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 31, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Line Church Cemetery</b>		22d. LOCATION (City, town, or county) <b>Near Whitesville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> <b>SALISBURY, MARYLAND</b>		24a. REC'D BY REGISTRAR <b>NOV 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kious</b>			

11977

CERTIFICATE OF DEATH

11977

Dec 1977

1. Name of Deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of Birth: [illegible]  
5. Date of Death: [illegible]  
6. Place of Death: [illegible]  
7. Cause of Death: [illegible]  
8. Physician: [illegible]  
9. Burial Place: [illegible]  
10. Signature: [illegible]

11. Registrar: [illegible]  
12. Date of Registration: [illegible]  
13. Signature: [illegible]  
14. Seal: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11988

## CERTIFICATE OF DEATH

Reg. Dist. No.

11979

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BABY GIRL</u> First Middle Last		4. DATE OF DEATH <u>MURRAY</u> Month <u>October</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Baby</u>	8. DATE OF BIRTH <u>October 29, 1959</u>
9. AGE (In years last birthday) <u>0</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>1</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>James G. Murray</u>		14. MOTHER'S MAIDEN NAME <u>Hilda Jean Myers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Dr. James G. Murray (Father)</u>		18. ADDRESS <u>Twin Tree Rd Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>762.5</u> IMMEDIATE CAUSE (a) <u>Atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>Prematurity Birth Wt 1055gms</u> (c) <u>approx 1 hour</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/29</u> , 19 <u>59</u> to <u>10/29</u> , 19 <u>59</u> , that I lost saw the deceased alive on <u>10/29</u> , 19 <u>59</u> , and that death occurred at <u>8:40</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred C. Kolls</u> M.D. <u>Medical Center</u>		DATE SIGNED <u>10/29/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Alfred C. Kolls-Medical Center</u>		<u>Salisbury Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 30, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY, MARYLAND</u>		24a. REC'D BY REGISTRAR <u>NOV 2 '59</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11980

11989

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>12</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		d. STREET ADDRESS <u>211 Marshall St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nottingham</u>		4. DATE OF DEATH Month Day Year <u>October 7 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7:10 A.M.</u> <u>Oct. 7, 1959</u>
9. AGE (In years last birthday) <u>0</u>		10. IF UNDER 1 YEAR Months Days Hours Min <u>0</u> <u>0</u> <u>0</u> <u>50</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury (Hospital) Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William Gilmer</u>		14. MOTHER'S MAIDEN NAME <u>Doris Marie Payne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. W. Gilmer Nottingham (Father) 211 Marshall St. Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydramnios - Congenital Encephalocele</u> DUE TO <u>Have big cleft palate Pre mature</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>Anencephalus</u> (c) <u>Anencephalus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-7</u> , 19 <u>54</u> , to <u>10-7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-7</u> , 19 <u>59</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>William S. Womack</u> M.D. <u>706 Camden Ave. Salis. Md. 10/7/59</u> PHYSICIAN'S NAME (Type) <u>Dr. William S. Womack</u> <u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 8, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		24a. REC'D BY REGISTRAR <u>OCT 9 '59</u>	
ADDRESS <u>SALISBURY MARYLAND</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	

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11990

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				e. d. STREET ADDRESS <b>R.F.D. #3</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Hattie</b> Middle <b>M.</b> Last <b>Nutter</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>4</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 11, 1870</b>	
9. AGE (In years last birthday) yrs. <b>89</b>		IF UNDER 1 YEAR Months <b>89</b> Days <b>89</b> Hours <b>89</b> Min. <b>89</b>		IF UNDER 24 HRS. Months <b>89</b> Days <b>89</b> Hours <b>89</b> Min. <b>89</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Marcellus Nutter</b>				14. MOTHER'S MAIDEN NAME <b>Hester Elzey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>unk</b>		INFORMANT <b>Hospital Records</b> Address <b>Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular disease decompensated</b> Years <b>422.1</b> DUE TO <b>Arteriosclerosis general</b> Years Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Sept. 28, 1959</b> , to <b>Oct. 4, 1959</b> , that I last saw the deceased alive on <b>Oct. 4, 1959</b> , and that death occurred at <b>10:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>10/4/59</b> ACTUAL SIGNATURE <b>Dr. V. Juerman</b> M.D. PHYSICIAN'S NAME (Type) <b>V. Juerman, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 7, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Nanticoke Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Nanticoke, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. J. Mpsaid, Bivdve, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1980

## CERTIFICATE OF DEATH

Reg. Dist. No.

11991

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>x</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>W. Headore</u> First Middle Last				4. DATE OF DEATH <u>October 8 1959</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 6 1959</u>		9. AGE (In years last birthday) <u>-</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>-</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>na</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>na</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Reuben Nutter</u>				14. MOTHER'S MAIDEN NAME <u>Marion Church</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>na</u>		16. SOCIAL SECURITY NO. <u>na</u>		INFORMANT <u>Marion Nutter</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atelectasis</u> DUE TO (c) <u>Prematurity - 895gms</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/6</u> , 19 <u>59</u> , to <u>10/8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/8</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>William C. Morgan</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-10-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Quintonia Cem</u>		22d. LOCATION (City, town, or county) (State) <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. West</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Thomas</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1185

CERTIFICATE OF DEATH

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*[Faint, mostly illegible handwritten text, likely a medical or legal record.]*

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11992 CERTIFICATE OF DEATH

11983

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Wic.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>12 Salisbury md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Samuel</i> First Middle Last		4. DATE OF DEATH <i>October 1</i> 19 <i>59</i> Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 30 1902</i>
9. AGE (In years last birthday) <i>57</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>va</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Joe Parker</i>		14. MOTHER'S MAIDEN NAME <i>Ella Garrison</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>222-10-4840</i>	
17. INFORMANT <i>Maggie Parker</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X Cerebrovascular Accident</i> DUE TO (b) <i>Hypertension</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>Indefinite</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1 Sept.</i> 19 <i>59</i> , to <i>1 Oct.</i> 19 <i>59</i> , that I last saw the deceased alive on <i>1 Oct.</i> 19 <i>59</i> , and that death occurred at <i>8:20 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. A. Purnell</i>		ADDRESS (Street, city or town, state) <i>652 W. Main</i> DATE SIGNED <i>3 Oct 59</i>	
PHYSICIAN'S NAME (Type) <i>E. A. Purnell, M.D. Salisbury, Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>Oct 5-1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill Cem</i>		22d. LOCATION (City, town or county) (State) <i>Salisbury md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Booker M. West</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 9 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>307 E. William St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARY SCARBOROUGH PETERS</b>				4. DATE OF DEATH <b>October 19 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 1, 1885</b>	
9. AGE (In years lost birthday) <b>74</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James S. Scarborough</b>				14. MOTHER'S MAIDEN NAME <b>Annie Bishop</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>*****</b>		17. INFORMANT <b>Frank H. Peters</b> Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Colon with local extension and</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastases.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a. m. p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>10/25</b> , 19 <b>59</b> , to <b>10/19</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10/16</b> , 19 <b>59</b> , and that death occurred at <b>5:38</b> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Pine Bluff Road, Salisbury, Maryland</b> DATE SIGNED <b>10/20/59</b> ACTUAL SIGNATURE <b>Rufus S. Gardner Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>Rufus S. Gardner, Jr. M.D. Pine Bluff Road, Salisbury, Maryland</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 22b. DATE THEREOF <b>10/21/1959</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Wahatoat Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>Snow Hill Maryland</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co.</b> ADDRESS <b>Salisbury, Maryland</b> 24a. REC'D BY REGISTRAR <b>OCT 22 59</b> DATE 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Plana</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1903

<p>1. NAME OF DECEASED                  JAMES J. JENNINGS</p>		<p>2. SEX                  Male</p>	
<p>3. AGE                  35</p>		<p>4. DATE OF BIRTH                  1868</p>	
<p>5. PLACE OF BIRTH                  Maryland</p>		<p>6. OCCUPATION                  Farmer</p>	
<p>7. CAUSE OF DEATH                  Heart Disease</p>		<p>8. PLACE OF DEATH                  Home</p>	
<p>9. DATE OF DEATH                  1903</p>		<p>10. TIME OF DEATH                  10:00 AM</p>	
<p>11. SIGNATURE OF DECEASED                  (Signature)</p>		<p>12. SIGNATURE OF WITNESSES                  (Signatures)</p>	
<p>13. SIGNATURE OF PHYSICIAN                  (Signature)</p>		<p>14. SIGNATURE OF CLERK                  (Signature)</p>	

15. COUNTY OF DEATH  
 16. STATE OF DEATH  
 17. CITY OF DEATH  
 18. ZIP CODE OF DEATH  
 19. NAME OF DECEASED  
 20. SEX  
 21. AGE  
 22. DATE OF BIRTH  
 23. PLACE OF BIRTH  
 24. OCCUPATION  
 25. CAUSE OF DEATH  
 26. PLACE OF DEATH  
 27. DATE OF DEATH  
 28. TIME OF DEATH  
 29. SIGNATURE OF DECEASED  
 30. SIGNATURE OF WITNESSES  
 31. SIGNATURE OF PHYSICIAN  
 32. SIGNATURE OF CLERK

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **11985**

**11994**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Miami</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>419 N. Eighth St.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Eunice</u> <u>Pugh</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>10-14-59</u> <u>19</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>C</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> 9. AGE (In years last birthday) <u>33</u> yrs.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Baltimore md</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>U. S. A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Clem Salley</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Jeanette Salley</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> <u>Jeanette Salley</u>	
<b>17. INFORMANT</b> <u>Jeanette Salley</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Fractured cervical spine</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in car involved in accident Route # 13.</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>4 P.M.</u> <u>10-14-59</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Route # 13</u>	
<b>20f. (City or town)</b> <u>Pocomoke Worcester Md.</u>		<b>20g. (County)</b> <u>Worcester</u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
<b>ACTUAL SIGNATURE</b> <u>Earl L. Royer</u>		<b>DATE SIGNED</b> <u>10-15-59</u>	
<b>EXAMINER'S NAME (Type)</b> <u>Earl L. Royer, M.D.</u>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>10-19-59</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Calvary Cem</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Anne Arundel Co</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Elroy O. Wilson</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Arthur S. Kraus</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>		<b>DATE</b> <u>OCT 19 '59</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## CERTIFICATE OF DEATH

Reg. Dist. No.

11986

11995

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Purcell</u>				4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-24-82</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland (Salisbury)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Henry Marvel</u>				14. MOTHER'S MAIDEN NAME <u>Ardelia Elizabeth Hearne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>		INFORMANT <u>Deer's Head Hospital Records</u> <u>Mr. J. Fulton Purcell (Son)</u> <u>Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Hypertensive arteriosclerotic cardiovascular dis.</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>  <u>Yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-21</u> , 19 <u>59</u> , to <u>10-27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-27</u> , 19 <u>59</u> , and that death occurred at <u>5:28 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>10-28-59</u>							
ACTUAL SIGNATURE <u>L. V. Maldve</u>		M.D. <u>Deer's Head State Hospital</u> <u>10-28-59</u>					
PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u>		<u>Salisbury, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 30, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 2 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of \_\_\_\_\_

City of \_\_\_\_\_

Age \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_ at \_\_\_\_\_

\_\_\_\_\_ died \_\_\_\_\_

\_\_\_\_\_ Cause of Death \_\_\_\_\_

\_\_\_\_\_ Signed \_\_\_\_\_

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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11996

## CERTIFICATE OF DEATH

Reg. Dist. No.

11987

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>		d. STREET ADDRESS <b>1 228 Newton St</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>MARTIN</b> Last <b>RICHMOND</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>9th</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. <u>MARRIED</u> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 10, 1898</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>29</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman-Self Employed- Safe Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Scotland</b>	
11. BIRTHPLACE (State or foreign country) <b>Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Richmond</b>		14. MOTHER'S MAIDEN NAME <b>Margaret M. Gamble</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES-W.W.#1(British Army)</b>		16. SOCIAL SECURITY NO. <b>INFORMANT Mrs. Mary K. Richmond (Wife) 228 Newton St Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary artery thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO <b></b> (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-8</b> , 19 <b>59</b> , to <b>10-9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10-9</b> , 19 <b>59</b> , and that death occurred at <b>12:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Oct. 10 / 1959</b>			
ACTUAL SIGNATURE <b>Wilber R. Ellis Jr.</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. Wilber R. Ellis Jr.</b>		Medical Center - Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 11, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 13 '59</b>	
ADDRESS <b>SALISBURY MARYLAND</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

CERTIFICATE OF DEATH

Age 100

RICHMOND

MALE

WHITE

Nov. 10, 1900

Residence

Married N. G. G.

Dr. W. H. Richmond (11-1225 Boston St.)  
City, Mass., Physician

Dec. 10, 1900

Medical Record - City of Boston

Dr. W. H. Richmond (11-1225 Boston St.)

Dr. W. H. Richmond (11-1225 Boston St.)

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS ATS (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11997

CERTIFICATE OF DEATH

Reg. Dist. No.

11988

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General Hospital</u>		d. STREET ADDRESS <u>19X-2</u>	
3. NAME OF DECEASED (Type or print) <u>ELMIRA SPENCER SMITH</u> First Middle Last		4. DATE OF DEATH <u>October 13 1959</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 23 1907</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Amick</u>		14. MOTHER'S MAIDEN NAME <u>Alice P.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>John Smith</u>	
17. INFORMANT <u>John Smith</u>		Address <u>2142 N. V. St. Phila., Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Hypertensive Cardiovascular Disease</u> (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/12</u> , 19 <u>59</u> , to <u>10/13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/13</u> , 19 <u>59</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>PINEBLUFF Rd. 10/13/59</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER JR.</u>		<u>SALISBURY, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-16-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lindley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>		24a. REG'D BY REGISTRAR <u>OCT 23 '59</u>	
ADDRESS <u>Edgar Wharton - New Church, Va.</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar Wharton</u>	

CERTIFICATE OF DEATH

1901

12 JAN 5 1901

1

11989

11998

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>120 Walston Ave</b>		d. STREET ADDRESS <b>120 Walston Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>ROSA</b> Middle <b>ALICE</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>13th</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 31, 1872</b>
9. AGE (In years lost birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR <b>6</b> Months <b>12</b> Days <b>12</b> Hours <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Wicomico County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William M. Gordy</b>		14. MOTHER'S MAIDEN NAME <b>Hester Oliphant</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mr. Louis B. Smith (Son) 120 Walston Ave. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 10/13, 1955</b> to <b>10/13, 1959</b> , that I last saw the deceased alive on <b>10/13, 1959</b> , and that death occurred at <b>3:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Earl Beardsley</b> M.D.		DATE SIGNED <b>October 6 1959</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Earl Beardsley</b>		<b>Maryland Ave. Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 16, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>OCT 19 '59</b>	24b. REGISTRAR'S SIGNATURE <b>William B. Smith</b>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11928

OFFICE OF THE ATTORNEY GENERAL

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11990

11959

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 may be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>604 Rose St</u>		d. STREET ADDRESS <u>604 Rose St</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Virginia</u> First <u>Smith</u> Last	4. DATE OF DEATH Month <u>10</u> Day <u>5</u> Year <u>1959</u>		
5. SEX <u>Fm</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15-1927</u>
9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chicken</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charlie Bacon</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>2-8-16-7890</u>	
17. INFORMANT <u>MARION BACON - Georgetown, DE</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>982x</u> DUE TO <u>Compound fracture of skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck in forehead &amp; eye</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a.m. <u>10-5</u> 19 <u>59</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		DATE SIGNED <u>10-13-59</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GREEN ACRES MEM PARK</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury</u> <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thornton B. Kelley, Salisbury MD</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 19 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

**DEATH CERTIFICATE**

**1. DECEASED**  
Name: \_\_\_\_\_  
Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Race: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Place of Birth: \_\_\_\_\_  
Usual Residence: \_\_\_\_\_  
Occupation: \_\_\_\_\_

**2. DEATH**  
Date: \_\_\_\_\_  
Time: \_\_\_\_\_  
Place: \_\_\_\_\_  
Cause: \_\_\_\_\_  
Manner: \_\_\_\_\_

**3. MEDICAL HISTORY**  
History of Present Illness: \_\_\_\_\_  
Past History: \_\_\_\_\_  
Family History: \_\_\_\_\_  
Social History: \_\_\_\_\_

**4. PHYSICAL EXAMINATION**  
Vital Signs: \_\_\_\_\_  
General Appearance: \_\_\_\_\_  
Head: \_\_\_\_\_  
Eyes: \_\_\_\_\_  
Ears: \_\_\_\_\_  
Nose: \_\_\_\_\_  
Throat: \_\_\_\_\_  
Lungs: \_\_\_\_\_  
Heart: \_\_\_\_\_  
Abdomen: \_\_\_\_\_  
Genitourinary: \_\_\_\_\_  
Skin: \_\_\_\_\_

**5. LABORATORY EXAMINATIONS**  
Hemoglobin: \_\_\_\_\_  
Hematocrit: \_\_\_\_\_  
Red Blood Cells: \_\_\_\_\_  
White Blood Cells: \_\_\_\_\_  
Platelets: \_\_\_\_\_  
Urinalysis: \_\_\_\_\_  
Stool Examination: \_\_\_\_\_  
Other: \_\_\_\_\_

**6. SIGNATURES**  
Medical Examiner: \_\_\_\_\_  
Attending Physician: \_\_\_\_\_  
Nurse: \_\_\_\_\_  
Other: \_\_\_\_\_

**7. CERTIFICATE NO.** \_\_\_\_\_

12000

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b> <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince St</b>		d. STREET ADDRESS <b>1 Prince St.</b>	
3. NAME OF DECEASED (Type or print) First <b>ASBURY</b> Middle <b>QUINTON</b> Last <b>TRUITT</b>		4. DATE OF DEATH Month <b>October</b> Day <b>29</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28, 1892</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR <b>9</b> Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer --</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Worcester Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Samuel H. Truitt</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Driscoll</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Myocardial Infarction</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic cardiovascular disease</b> DUE TO <b>Arteriosclerotic cardiovascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Minutes</b> <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/12/58</b> to <b>10/29/59</b> , that I last saw the deceased alive on <b>10/19/59</b> , and that death occurred at <b>12:20 A.M.</b> , from the causes and on the date stated above.		DATE SIGNED <b>Oct. 30/59</b>	
ACTUAL SIGNATURE <b>[Signature]</b> M.D.		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <b>Dr. O. J. Burton</b>		<b>Maryland Ave. Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov 1, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>NOV 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. H. H.</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11992

12001

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SANSBURY</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE RAYMOND</u> First Middle Last <u>TRUITT, Jr.</u>		4. DATE OF DEATH <u>October 27</u> 19 <u>59</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 10, 1891</u> 68 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>DELAWARE</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DELAWARE</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE RAYMOND TRUITT</u>		14. MOTHER'S MAIDEN NAME <u>ELLA HELENS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not any - Mrs. Audrey B. Truitt, Federalsburg, Md. R.R.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> (c) <u>Intestinal obstruction due to carcinoma rectum</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/24</u> , 19 <u>59</u> , to <u>10/27</u> , 19 <u>59</u> that I last saw the deceased alive on <u>10/27</u> , 19 <u>59</u> , and that death occurred at <u>7:05</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. H. Briele</u>		ADDRESS (Street, city or town, state) <u>Federalsburg, Md.</u> DATE SIGNED <u>10/28/59</u>	
PHYSICIAN'S NAME (Type) <u>H. H. Briele</u>		M.D. <u>Wilmington, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-29-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest</u>		22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. R. H. Boyer, Harrington, Del.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 4 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Robert S. ...</u>	

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CERTIFICATE OF DEATH

1901

WILLIAM J. HAYWARD

Wichita

Age 45 years, male, white, single, born in England, died of heart disease.

Dec. 23, 1901, at his residence, 1234 Main St., Wichita, Kan.

Dr. J. H. Smith, M.D., attending physician.

Witnessed by J. H. Smith, M.D., and J. H. Jones, M.D.

Filed for record Dec. 25, 1901.

Recorded Dec. 26, 1901.

W. H. Jones, Registrar.

W. H. Jones, Registrar.

12017

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>		c. LENGTH OF STAY IN 1b <b>74 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>412 Pine Street</b>		d. STREET ADDRESS <b>412 Pine Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>C.</b> Last <b>Truitt</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>26</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 16, 1885</b>
9. AGE (In years lost birthday) <b>74 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Silas James Truitt</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Morris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>711-07-1575</b>	
17. INFORMANT <b>Esther Truitt, Delmar, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Advanced arteriosclerosis</b> DUE TO (c) <b>Cardio-renal disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 Wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>59</b> , to <b>10-26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10-25</b> , 19 <b>59</b> , and that death occurred at <b>2 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Delmar, Del.</b> DATE SIGNED <b>10/27/59</b>			
ACTUAL SIGNATURE <b>W. J. Truitt</b>		M.D. <b>Laurel Del</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-29-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Delmar, Del.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. S. Marvel Co - Delmar, Del.</b>		24. REC'D BY REGISTRAR DATE <b>OCT 29 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11315

CERTIFICATE OF DEATH

19017

Decedent's Name: *William J. Smith*  
Age: *74 years*  
Sex: *Male*  
Race: *White*  
Date of Birth: *June 10, 1882*  
Place of Birth: *Wilmington, Delaware*  
Usual Residence: *Wilmington, Delaware*  
Cause of Death: *Old age*  
Date of Death: *July 1, 1951*  
Place of Death: *Wilmington, Delaware*  
Signature of Physician: *W. J. Smith*  
Signature of Registrar: *W. J. Smith*

*W. J. Smith*  
*July 1, 1951*  
*Wilmington, Delaware*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11994

Reg. Dist. No.

12002

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>5 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>RFD</b>			
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Turner</b> Last <b>Turner</b>				4. DATE OF DEATH Month <b>10</b> Day <b>21</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 8, 1875</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months <b>21</b> Days <b>21</b>		IF UNDER 24 HRS. Hours <b>21</b> Min. <b>19</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Henry Turner</b>				14. MOTHER'S MAIDEN NAME <b>Mary Downey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>X</b>		16. SOCIAL SECURITY NO. <b>X</b>		17. INFORMANT Address <b>Mrs. Emma J. Turner Bishop, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture ribs &amp; Fracture of left humerus</b>							INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Walked in front of auto</b>					
20c. TIME OF INJURY Month, Day, Year <b>11:45 a.m. 10/17/1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Bishop Worcester Md</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Earl L. Royer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Earl L. Royer</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Buried</b>		22b. DATE THEREOF <b>10/24/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>I. O. O. F.</b>		22d. LOCATION (City, town, or county) (State) <b>Bishop ville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rita Whaley Salisbury Md</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - BATHING IS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12005

NAME OF DECEASED JAMES E. SMITH		AGE 45		SEX Male		RACE White	
DATE OF DEATH 1918		PLACE OF DEATH St. Louis		CAUSE OF DEATH Typhoid		MANNER OF DEATH Natural	
RESIDENCE St. Louis		OCCUPATION Teacher		EDUCATION High School		RELIGION Catholic	
MARITAL STATUS Married		SPOUSE'S NAME Mary Smith		CHILDREN 3		BIRTH DATE 1918	
DATE OF BIRTH 1918		PLACE OF BIRTH St. Louis		PARENTS' NAMES John & Mary Smith		FAMILY HISTORY None	
PREVIOUS ILLNESS Typhoid		TREATMENT Hospital		PHYSICIAN'S NAME Dr. Smith		HOSPITAL NAME St. Louis	
DATE OF EXAMINATION 1918		EXAMINER'S NAME Dr. Smith		SIGNATURE [Signature]		STAMP [Stamp]	

1

## CERTIFICATE OF DEATH

11995

Reg. Dist. No.

12018

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parsonburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parsonburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D.</u>		d. STREET ADDRESS <u>R.F.D.</u>	
3. NAME OF DECEASED (Type or print) <u>P. Frank Lyle</u>		4. DATE OF DEATH <u>10/16/1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/19/1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Benjamin Lyle</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Foskey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>22-14-KX4</u>	
17. INFORMANT <u>Janie Lyle - Parsonburg - Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> DUE TO <u>Chronic Myocardial Decompensation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocardial Decompensation</u> DUE TO (c) <u>Chronic Myocardial Decompensation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-2</u> , 19 <u>59</u> to <u>10-16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-14</u> , 19 <u>59</u> , and that death occurred at <u>6 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>V. A. Hudson</u>		DATE SIGNED <u>10-17-59</u>	
PHYSICIAN'S NAME (Type) <u>V. A. Hudson M.D.</u>		ADDRESS (Street, city or town, state) <u>Millers Del</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/19/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Line Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pittsville Md. R.F.D.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald James Millers Del</u>		24. REC'D BY REGISTRAR <u>Oct 20 59</u>	
ADDRESS <u>Millers Del</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11996

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>12003</b> <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b> 19x-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>Jarmon Farm Box 57</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lorraine Vinson</b>				4. DATE OF DEATH Month Day Year <b>10-3-59</b> 19			
5. SEX <b>F</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1920</b>	
				9. AGE (In years last birthday) <b>39</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Fla</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Earl L. Vinson</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Spontaneous sub-arachnoid hemorrhage</b> 330x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Earl L. Royer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10-8-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 10-8-59</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>St. Calvary</b>		22d. LOCATION (City, town, or county) (State) <b>Princess Anne Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Booker Kent</b>				24a. REC'D BY REGISTRAR <b>OCT 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur [Signature]</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. To execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. OCCUPATION <i>Teacher</i>		5. MARITAL STATUS <i>Married</i>		6. PLACE OF BIRTH <i>Baltimore, Md.</i>	
7. DATE OF DEATH <i>Jan 15, 1920</i>		8. TIME OF DEATH <i>10:30 AM</i>		9. PLACE OF DEATH <i>Home</i>	
10. CAUSE OF DEATH <i>Myocardial infarction</i>					
11. MANNER OF DEATH <i>Natural</i>					
12. SIGNATURE OF EXAMINER <i>John Doe</i>					
13. SIGNATURE OF WITNESSES <i>John Doe</i>					
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12019

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>				c. LENGTH OF STAY IN TB <u>Lifetime</u> x <u>Nanticoke</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ROBERT J. WALLACE</u>				4. DATE OF DEATH <u>Oct. 1</u> 19 <u>59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-6-1880</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Oysterman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Robert Wallace</u>				14. MOTHER'S MAIDEN NAME <u>Louise Hardy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>19-34-3337A</u>			
17. INFORMANT <u>Hillary Wallace</u>				Address <u>Nanticoke, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.0</u> DUE TO <u>Chronic Calcific Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>1 day</u> (c) <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Trauma</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>21 July, 1959</u> to <u>1 Oct</u> , 1959, that I last saw the deceased alive on <u>1 Oct</u> , 1959, and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.				ADDRESS (Street, city or town, state) <u>Nanticoke, Md.</u> DATE SIGNED <u>2 Oct 59</u>			
PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>				<u>Nanticoke, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nanticoke Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Nanticoke, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. Professor, Bivalve, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE OCT 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first step in the process of identifying a problem is to define the problem. This involves identifying the symptoms of the problem and determining the scope of the problem. Once the problem has been defined, the next step is to identify the causes of the problem. This involves identifying the factors that are contributing to the problem and determining the underlying causes. Once the causes have been identified, the next step is to develop a plan of action. This involves identifying the steps that need to be taken to solve the problem and determining the resources that will be needed to implement the plan. Once a plan of action has been developed, the next step is to implement the plan. This involves carrying out the steps that have been identified in the plan and monitoring the progress of the implementation. Finally, the last step in the process is to evaluate the results of the implementation. This involves determining whether the problem has been solved and whether the resources have been used effectively.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12004

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>WILLIAM</b> First <b>WHITELEY</b> Middle <b>WALLER</b> Last		4. DATE OF DEATH <b>OCTOBER</b> Month <b>17th</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14, 1892</b>
9. AGE (In years lost birthday) <b>67</b> yrs.		IF UNDER 1 YEAR <b>4</b> Months <b>9</b> Days	IF UNDER 24 HRS. <b>9</b> Hours <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>	11. BIRTHPLACE (State or foreign country) <b>Delmar, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			

13. FATHER'S NAME <b>William J. Waller</b>		14. MOTHER'S MAIDEN NAME <b>Virgie Emma Williams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT Mrs. Catherine L. Waller (Wife) 428 E. Church St. Salisbury, Maryland</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X Central vascular accident</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid arthritis - Chronic myocarditis</b>		INTERVAL BETWEEN ONSET AND DEATH
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <b>1950</b> to <b>10-17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10-17</b> , 19 <b>59</b> , and that death occurred at <b>2:20 A.M.</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Philip A. Insley</b>	DATE SIGNED <b>Oct. 19 / 1959</b>
PHYSICIAN'S NAME (Type) <b>Dr. Philip Insley</b> <b>Main St. Salisbury, Maryland</b>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 19, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY, MARYLAND</b>		24a. REC'D BY REGISTRAR <b>OCT 20 '59</b> DATE	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

CERTIFICATE OF TITLE

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C. 20250

TO HAVE AND TO HOLD unto the said

of the County of \_\_\_\_\_ State of \_\_\_\_\_

for and to the said \_\_\_\_\_

and to the heirs, assigns and assigns forever

of the County of \_\_\_\_\_ State of \_\_\_\_\_

for and to the said \_\_\_\_\_

and to the heirs, assigns and assigns forever

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12005

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>M. ryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>Riverside Dr.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>PERRY ALEXANDER WHITE</b>				4. DATE OF DEATH Month Day Year <b>10 16 1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 30, 1899</b>	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>J.W. White Candy Wholesale Retired owner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joh<sup>W</sup>. White</b>				14. MOTHER'S MAIDEN NAME <b>Angie Webster</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Beatrice White, Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>4-13</b> , 19 <b>59</b> , to <b>10-16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10-16</b> , 19 <b>59</b> , and that death occurred at <b>3:00 PM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b>				DATE SIGNED <b>10-16-59</b>			
ACTUAL SIGNATURE <b>Earl L. Royer</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Dr. Earl L. Royer Camden Ave., Salisbury, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-18-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 19 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

Norman T Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12020

## CERTIFICATE OF DEATH

Reg. Dist. No.

12000

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharptown</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Main Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <b>Main Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bernard Lewis Wilkinson</b>				4. DATE OF DEATH Month Day Year <b>OCTOBER Aug. 11, 1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1895</b>	9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Drugs</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Wilkinson</b>				14. MOTHER'S MAIDEN NAME <b>Lillie Seabrease</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW # 1 218-05-8028</b>		17. INFORMANT Address <b>Mary Bailey Wilkinson, Sharptown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Coronary Insufficiency</b> DUE TO (c) <b>10 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1950</b> to <b>Oct 17, 1959</b> , that I last saw the deceased alive on <b>Oct 11, 1959</b> , and that death occurred at <b>6:00</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. S. Kuklieman</b> M.D.				ADDRESS (Street, city or town, state) <b>Sharptown Md</b>			
PHYSICIAN'S NAME (Type) <b>H. S. Kuklieman</b>				DATE SIGNED <b>10/15/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-14-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Taylor</b>		22d. LOCATION (City, town, or county) (State) <b>Sharptown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles W. Gandy - Sharptown</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-80 BY SP-5 JLM/STW

1980

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
CERTIFICATE OF DEATH

1980

1. Name of Deceased [Illegible]		2. Sex [Illegible]		3. Race [Illegible]	
4. Date of Birth [Illegible]		5. Date of Death [Illegible]		6. Place of Birth [Illegible]	
7. Usual Residence [Illegible]		8. Cause of Death [Illegible]		9. Manner of Death [Illegible]	
10. Signature of Physician [Illegible]		11. Signature of Registrar [Illegible]		12. Signature of Medical Examiner [Illegible]	
13. Signature of Coroner [Illegible]		14. Signature of Funeral Home [Illegible]		15. Signature of Burial Place [Illegible]	
16. Signature of Cemetery [Illegible]		17. Signature of Burial Place [Illegible]		18. Signature of Burial Place [Illegible]	
19. Signature of Burial Place [Illegible]		20. Signature of Burial Place [Illegible]		21. Signature of Burial Place [Illegible]	
22. Signature of Burial Place [Illegible]		23. Signature of Burial Place [Illegible]		24. Signature of Burial Place [Illegible]	
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67. Signature of Burial Place [Illegible]		68. Signature of Burial Place [Illegible]		69. Signature of Burial Place [Illegible]	
70. Signature of Burial Place [Illegible]		71. Signature of Burial Place [Illegible]		72. Signature of Burial Place [Illegible]	
73. Signature of Burial Place [Illegible]		74. Signature of Burial Place [Illegible]		75. Signature of Burial Place [Illegible]	
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79. Signature of Burial Place [Illegible]		80. Signature of Burial Place [Illegible]		81. Signature of Burial Place [Illegible]	
82. Signature of Burial Place [Illegible]		83. Signature of Burial Place [Illegible]		84. Signature of Burial Place [Illegible]	
85. Signature of Burial Place [Illegible]		86. Signature of Burial Place [Illegible]		87. Signature of Burial Place [Illegible]	
88. Signature of Burial Place [Illegible]		89. Signature of Burial Place [Illegible]		90. Signature of Burial Place [Illegible]	
91. Signature of Burial Place [Illegible]		92. Signature of Burial Place [Illegible]		93. Signature of Burial Place [Illegible]	
94. Signature of Burial Place [Illegible]		95. Signature of Burial Place [Illegible]		96. Signature of Burial Place [Illegible]	
97. Signature of Burial Place [Illegible]		98. Signature of Burial Place [Illegible]		99. Signature of Burial Place [Illegible]	
100. Signature of Burial Place [Illegible]		101. Signature of Burial Place [Illegible]		102. Signature of Burial Place [Illegible]	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12006

Item 7 Film G250 10-28-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

12001

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		19X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>R.F.D.</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah (SEWELL) Williams</u>		4. DATE OF DEATH Month Day Year <u>October 21 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 15, 1909</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>GEORGE WILLIAMS</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH TAYLOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>DAISY JOHNSON, CRISFIELD, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Renal Failure with Uremia</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Kimmelsteil-Wilson Syndrome</u> DUE TO (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 19, 1959</u> , to <u>October 21, 1959</u> , that I last saw the deceased alive on <u>October 20, 1959</u> , and that death occurred at <u>5:04 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Prize Bluff Road</u> DATE SIGNED <u>10/21/59</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS C. HILL, JR.</u>		<u>Salisbury, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT 24, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EBENEZER CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>MARION, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BRADSHAW</u>		ADDRESS <u>JOHN CRISFIELD, MD</u>	
24a. REC'D BY REGISTRAR <u>DATE OCT 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hearn</u>	

Chronic renal failure with uremia  
 Kimweli 1. U. 1200 2. 1200  
 Diabetic Mellitus

October 20 22 PI 22 October 21 22  
 October 20 22 PI 22 October 21 22

Theresa C. Hill  
 10/21/21  
 10/21/21  
 10/21/21

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2. See: Birth Cert. et

12007

CERTIFICATE OF DEATH

Reg. Dist. No.

13147

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>			d. STREET ADDRESS <u>Rt. # 3, Box # 1</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>WOLFKILL</u>			4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 29, 1959</u>		9. AGE (In years last birthday) <u>1 day</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
13. FATHER'S NAME <u>Edgar Wolfkill</u>			14. MOTHER'S MAIDEN NAME <u>Virginia Adkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>atelectasis</u> DUE TO (c) <u>Prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from <u>10/29 1959</u> , to <u>10/30 1959</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above.						
ACTUAL SIGNATURE <u>W. F. B. Smith</u>		M.D. <u>W. A. Carter</u>		DATE SIGNED <u>11/1/59</u>		
PHYSICIAN'S NAME (Type)						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beechwood Memorial</u>		
22d. LOCATION (City, town, or county) (State)		<u>Princess Anne Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Hannon</u>		ADDRESS <u>Princess Anne</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 18 '59</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>						

2082201XV2

18142

CERTIFICATE OF DEATH

13003

WITNESSES  
SUBSCRIBED AND SWORN to before me this 1st day of May 1914

CLERK OF THE DISTRICT COURT

WITNESSES

DECEASED

WITNESSES

DECEASED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12008

CERTIFICATE OF DEATH

Reg. Dist. No. 12002

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WALSIE</u> Middle <u>MAG</u> Last <u>Wootten</u>		4. DATE OF DEATH Month <u>October</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 4, 1904</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>WILEYSVILLE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>URIAH HUDSON</u>		14. MOTHER'S MAIDEN NAME <u>SARAH CAREY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>MR. HARRY L. WOOTTEN, WILLYARDS MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>197.3 METASTATIC FIBROSARCOMA.</u> DUE TO (b) <u>FIBROSARCOMA - THIGH - LEFT.</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>9-12</u> , 19 <u>59</u> , to <u>10-12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-12</u> , 19 <u>59</u> , and that death occurred at <u>8:29</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. Gray Rees</u>		DATE SIGNED _____	
PHYSICIAN'S NAME (Type) _____		ADDRESS (Street, city or town, state) <u>Medical Center, Salisbury, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/15/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burby Berlin Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 15 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneib</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12009 CERTIFICATE OF DEATH

12003

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Caroline</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b <b>159 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b> <span style="float: right;"><b>05X-2</b></span>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>220 S. Main Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Laura Virginia Wothers</b>				<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>20</b> Year <b>19 59</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>5/12/1869</b>	
<b>9. AGE</b> (In years last birthday) yrs. <b>90</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Months Days Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Housework</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland (Caroline Co.)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>Ezekiel Jarrell</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Clark</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Unk.</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>INFORMANT</b> <b>Deer's Head Hospital</b> Address <b>Records</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, general</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from <u>May 14</u>, 19<u>59</u>, to <u>October 20</u>, 19<u>59</u>, that I last saw the deceased alive on <u>October 20</u>, 19<u>59</u>, and that death occurred at <u>1:15 AM</u>, from the causes and on the date stated above.</b> ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>10/20/59</b> ACTUAL SIGNATURE <b>L. V. Maldve</b> M.D. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b> <b>Salisbury, Maryland</b>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>Oct. 23, 1959</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Hill Crest Cemetery</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Federalsburg, Maryland</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J.J. Frempton and Son, Federalsburg, Maryland</b>				<b>24b. REC'D BY REGISTRAR</b> <b>DATE OCT 22 '59</b>		<b>24c. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kraus</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12010

CERTIFICATE OF DEATH

12009

MADE HAMBURG STATEMENT OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of declarant: [illegible]  
9. Signature of witness: [illegible]  
10. Signature of official: [illegible]

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12010

## CERTIFICATE OF DEATH

12004

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>314 Delaware Street</u>				d. STREET ADDRESS <u>314 Delaware Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Norman</u> Middle <u>R.</u> Last <u>Wright</u>				4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 4, 1892</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilmore Wright</u>				14. MOTHER'S MAIDEN NAME <u>Merniva King</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Sophia Robinson</u> Address <u>102 Second St Salisbury</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Thrombosis</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Salisbury</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 Sept. 1958</u> to <u>4 Oct. 1959</u> , that I last saw the deceased alive on <u>4 Oct. 1959</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. A. Purnell</u>				ADDRESS (Street, city or town, state) <u>652 W. Main St Salisbury Md.</u>		DATE SIGNED <u>9 Oct. 1959</u>	
PHYSICIAN'S NAME (Type) <u>E. A. Purnell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/9/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u> ADDRESS <u>Salisbury</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>	

CERTIFICATE OF DEATH

1910

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15 1865		Boston, Mass.	
Cause of Death		Disease		Duration		Time of Day		Place of Death	
Heart Disease		Myocardial Infarction		2 Weeks		10:30 AM		Home	
Occupation		Profession		Education		Religion		Marital Status	
Clerk		Teacher		High School		Roman Catholic		Married	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Death		Time of Death		Place of Death		Cause of Death		Disease	
Jan 20 1910		10:30 AM		Home		Heart Disease		Myocardial Infarction	
Buried		Interred		Cremated		Other		Disposition	
Yes		No		No		No		Buried	
Burial Place		Interment Place		Cremation Place		Other Place		Disposition	
St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		Buried	
Burial Date		Interment Date		Cremation Date		Other Date		Disposition	
Jan 22 1910		Jan 22 1910		Jan 22 1910		Jan 22 1910		Buried	
Burial Time		Interment Time		Cremation Time		Other Time		Disposition	
10:00 AM		10:00 AM		10:00 AM		10:00 AM		Buried	
Burial Place		Interment Place		Cremation Place		Other Place		Disposition	
St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		Buried	
Burial Date		Interment Date		Cremation Date		Other Date		Disposition	
Jan 22 1910		Jan 22 1910		Jan 22 1910		Jan 22 1910		Buried	
Burial Time		Interment Time		Cremation Time		Other Time		Disposition	
10:00 AM		10:00 AM		10:00 AM		10:00 AM		Buried	

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